Laconia Eye Associates, P.A.
d/b/a Laconia Eye & Laser Center

Signature on File, Assignment of Benefits, Financial Agreement, HIPAA Notice

Patient Name: Medicare #:

1. MEDICARE and MEDIGAP: I request that payment of authorized Medicare and Medigap benefits be made on my behalf to Laconia Eye Associates for services furnished me by Drs'. Feller, Garfinkle, Lawrence, Savard, Scott, Talkington and Vishton. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form, my signature authorizes releasing the information to the insurer or agency shown. Laconia Eye Associates accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

2. OTHER INSURANCE: I authorize payment of my medical and surgical insurance benefits to Laconia Eye Associates. I understand I am financially responsible for any charges not paid by said insurance. If payment has not been received from my insurance company after 45 days from date of service, the balance becomes my responsibility. Any conflicts with my insurance company will have to be handled by me. I agree to pay any co-payments and/or deductibles designated by my insurance company or health plan to Laconia Eye Associates. I authorize Laconia Eye Associates to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

3. NON-COVERED SERVICES: I understand that Laconia Eye Associates' contract with health care services plans (i.e., HMOs, PPOs) relates only to items and services which are "covered" by the health care service plans. Accordingly, I accept full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. **Charges for refractions are due at time of service.** Refraction is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. Most medical insurances do not cover this as they consider it to be a routine service. I agree to cooperate with Laconia Eye Associates to obtain necessary health care service plan authorizations. If you have Medicare, but Medicare may deem the prescribed treatment as "medically unnecessary" according to HCFA payment guidelines, you will be requested to sign a waiver (advance beneficiary notice) prior to treatment and payment for the service is due at the time of service.

4. FINANCIAL AGREEMENT: Payment is due at time of service. We accept cash, personal checks, debit and credit cards. All deductibles, co-pays, and non-covered services are due at the time of service unless payment arrangements have been made in advance. Patient balances unforseen at time of service will be billed to the address you have provided for billing purposes. It is your responsibility to inform us of any changes in address, phone, or employment. All balances are due in full within 14 days of the billing date. If you cannot pay the balance in full within 14 days, please contact our office to see if you qualify for any special payment arrangement options. Our office treats patients regardless of financial status. If you have no insurance, have maximized your benefits, have a high deductible, or you are currently medically indigent or financially indigent but not eligible for Public Assistance or Medicaid, please ask to speak with the Financial Manager. You need to provide a copy of last year's tax returns and current pay check stubs to be considered for assistance with our office.

I agree that in return for the services provided to me by Laconia Eye Associates, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Laconia Eye Associates for payment. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Laconia Eye Associates. However, I understand that I am primarily responsible for the payment of my bill. If my account is sent to an agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate.

5. HIPAA NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received the Notice of Privacy Practices issued by Laconia Eye Associates that was effective August 1, 2010. Revised 03/08/2022

Patient Signature or Authorized Party **Date**